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Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System

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Summary

The Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule (MPFS). Under the SGR formula, if expenditures over a period are less than the cumulative spending target for the period, the annual update is increased. However, if spending exceeds the cumulative spending target over a certain period, future updates are reduced to bring spending back in line with the target.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services). Beginning in 2002, the actual expenditure exceeded allowed targets, and the discrepancy has grown with each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions.

Most observers agree that the SGR system is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries: (1) the SGR system treats all services and physicians equally in the calculation of the annual payment update, which is applied uniformly with no distinction across specialties; (2) continued declines in physician payment rates, especially among primary care specialties, may potentially jeopardize access to services; and (3) legislative overrides have provided only temporary reprieve from projected reductions in payments under the SGR calculation, requiring even steeper future reductions in payment rates.

On February 5, 2013, CBO stated that its estimate of the cost of a 10-year freeze in payments had fallen to $138 billion over 10 years, more than $100 billion less than its August 2012 estimate, primarily due to lower spending for physician services. In December 2013, CBO issued another score indicating that a 10-year freeze would cost $116.5 billion over 10 years.

Each of the three committees of jurisdiction passed bills in 2013 that would repeal the SGR system. The bills would provide an initial period of payment stability: the Energy and Commerce bill would increase MPFS payments by 0.5% each year from 2014 to 2018, the Senate Finance Committee bill would freeze the payments (0% increase) for 10 years from 2014 to 2023, and the Ways and Means bill would increase payments by 0.5% in 2015 and 2016. Second, they each establish the development of new payment systems while maintaining fee-for-service payment in a manner similar to the existing system. Third, they each create incentives for physicians to transition to the new payment systems over time, generally by establishing different rates of increase over time for the new payment systems compared to fee-for-service. However, none of the bills was passed by both houses of Congress.

H.J.Res. 59 (signed into law on December 26, 2013) included the Pathway for SGR Reform Act, which provided for a 0.5% increase in MPFS payments for three months, from January 1, 2014, through March 31, 2014. The Protecting Access to Medicare Act (PAMA, P.L. 113-93) was signed into law on April 1, 2014, and provided a 12-month override of the SGR-directed payment reduction, keeping Medicare fee schedule payments at the current level through March 31, 2015.

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Introduction

The Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule (MPFS). The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the volume or mix of services.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services). In 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years. However, beginning in 2002, the actual expenditure exceeded allowed targets, and the discrepancy has grown with each year, resulting in a series of ever-larger cuts under the formula.

With the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions. However, these actions have required almost yearly attention from Congress. This report provides a background on the Medicare fee schedule, the SGR system, and the annual updates and discusses recent proposals to address this issue.

Background on the Medicare Fee Schedule Updates

Medicare payments for Part B services[1] provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare.[2] From the inception of the program until 1992 and the introduction of the resource-based relative value scale (RB-RVS) fee schedule, Medicare paid physicians based on "usual, customary, and reasonable" charges.[3]

The Omnibus Budget Reconciliation Act (OBRA 89, P.L. 101-239) created the RB-RVS-based Medicare fee schedule, which went into effect January 1, 1992. Under the RB-RVS fee schedule, the Center for Medicare & Medicaid Services (CMS) assigns relative value units (RVUs) that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs.[4] The adjusted relative values are then multiplied by a conversion factor to derive the actual payment amount in dollars. Medicare pays providers the lesser of the actual charge for the service or the allowed amount under the fee schedule.

Expenditure targets have been a factor in the calculation of Medicare physician payment updates since the current fee schedule was first implemented in 1992. In the first year, one overall

[1] For detail on fee-for-service Medicare and other Medicare background information, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[2] Social Security Act, §1848. [42 U.S.C. 1395w–4]. In some instances, special rules apply to the calculation of Medicare fees for some services, including anesthesia, radiology, and nuclear medicine.

[3] Also called "customary, prevailing and reasonable charges," this method based physician payments on charges commonly used by physicians in a local community. The payment for a service was the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. For further discussion, see Physician Payment Review Commission, "Annual Report to Congress, 1997."

[4] The determination of the relative value units affects all payments under the fee schedule. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association's Specialty Society Relative Value Update Committee (RUC), which receives input from approximately 100 specialty societies. The law requires a review every five years.

conversion factor was used to calculate the update. Then, two (surgical and non-surgical services) and eventually three conversion factors were used for different categories of services (surgical, primary care, and other nonsurgical services). However, under the Medicare Volume Performance Standard (MVPS) method, targets were set (and typically exceeded) each year; there was no cumulative goal and no significant consequence to exceeding the expenditure target. The current SGR method for calculating annual updates was created partly in response to the shortcomings of the prior method.

Updates and the Sustainable Growth Rate (SGR) System

The Balanced Budget Act of 1997 (BBA97, P.L. 105-33) replaced the MVPS with the SGR, with the objective of creating a *sustainable* growth path for Part B expenditures. First, BBA97 added cumulative spending criteria that resulted in actual consequences for failing to meet expenditure targets; beginning with April 1, 1996, as the starting point, actual program expenditures are compared to growth targets to determine annual updates. Second, BBA 97 introduced the rate of growth in the per capita amount of the gross domestic product (GDP) into the SGR calculation and also provided for the use of a single conversion factor instead of three.[5] By tying the expenditure targets to the growth in GDP per capita, this system attempted to hold Medicare physician expenditures to a level that would not consume an ever-increasing share of national income.

The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the volume or mix of services. The SGR system was intended to serve as a restraint on aggregate spending. While the SGR targets are not limits on expenditures, they represent a "sustainable" trajectory for cumulative spending on Medicare physician services from April 1996 forward. The annual fee schedule update thus reflects the success or failure in meeting the goal. If expenditures over a period are less than the cumulative spending target for the period, the update is increased. However, if spending exceeds the cumulative spending target over a certain period, the update for a future year is reduced, with the goal to bring spending back in line with the target.

Since the conversion factor applies to all services, the update to the conversion factor is the key component for determining how reimbursements change from year to year.

Conversion Factor Calculation

The Medicare conversion factor is a scaling factor that converts the geographically adjusted number of RVUs for each service in the Medicare physician payment schedule into a dollar payment amount. The annual update to the conversion factor calculation is based on (1) the MEI, which measures the weighted-average annual price changes in the inputs needed to produce physician services;[6] (2) the SGR; and (3) the update adjustment factor (UAF).

[5] The Balanced Budget Refinement Act of 1999 (BBRA 99, P.L. 106-113) incorporated an adjustment for the prior year into the update adjustment factor (UAF) update calculation; it also moved from a fiscal year to a calendar year system.

[6] For more information on the components used to calculate the MEI and quarterly historical data, see http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/mktbskt-economic-index.pdf. The 2013 MEI estimate is contained in CMS' preliminary estimate of the SGR and conversion factor for 2013, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2013p.pdf.

Medicare Economic Index

The Medicare Economic Index is a factor in the annual update to the physician fee schedule. The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. In 2013, the MEI is projected to increase 0.6%.[7] In years when the cumulative actual expenditures equal the target, physician fees are updated by the growth rate in the MEI.

Sustainable Growth Rate (SGR)

The SGR sets both the cumulative and allowed expenditures under the UAF formula and consists of the following components:

- the estimated percentage changes in physicians fees,
- the estimated percentage changes in the number of fee-for-service beneficiaries,
- the estimated percentage growth in real GDP per capita (10-year moving average), and
- the estimated percentage changes resulting from changes in laws and regulations.

Because the SGR formula is tied to the percentage change in the number of fee-for-service beneficiaries, in the short run, increases in managed care enrollment relative to fee-for-service Medicare would result in a slightly lower SGR. In the longer run, as the population ages and the number of fee-for-service Medicare beneficiaries increases, this should increase the target rate of allowed expenditures.

Prior to 2003, the SGR formula included as a component the annual rate of growth in the economy (i.e., the growth in inflation-adjusted GDP per capita). From 1997 through 2000, per capita GDP grew faster than Part B expenditures, at more than 4% annually; Part B expenditures were relatively stable from 1996 to 1998 and then started to increase in 1999 and 2000. However, economic growth slowed at the turn of the century, while Part B expenditures grew at a faster rate from 2000 on. Thus, the relative health of the economy effectively masked the increases in total Part B expenditures for the first few years under the SGR system, but as the economy slowed and expenditures continued to increase, the updates as determined under the SGR system turned negative in order to bring projected actual expenditures back in line with target expenditures. To remove some of the volatility in the target from cyclical economic changes, the Medicare Modernization Act (P.L. 108-173) changed the measure to a (10-year moving average) real GDP per capita growth rate.

Beginning in CY2010, there was a technical adjustment to the calculation of the SGR relating to how physician services are measured. Specifically, physicians have argued that physician-administered drugs (which are reimbursed under Part B) should be excluded from the calculation of expenditures subject to the SGR because physicians have no control or influence on the price of these drugs. To address this issue, CMS changed the measurement of physician services to exclude physician-administered drugs from the calculation of allowed and actual expenditures beginning in CY2010 and all subsequent years. For comparison purposes, they also calculated cumulative allowed and actual physician-expenditures excluding physician-administered drugs for all prior years as well (see **Figure 1**).[8] The Congressional Budget Office (CBO) projects that

[7] The calculation of the 2012 MEI is provided in the final 2012 Medicare physician payment rule issued by CMS; see http://www.ofr.gov/OFRUpload/OFRData/2011-28597_PI.pdf.

[8] See CMS Final Rule, *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions*

removal of physician-administered drugs from the target should reduce the difference between actual and targeted spending in the future as spending for physician-administered drugs has historically grown faster than physician services.[9]

Update Adjustment Factor

The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. The adjustment factor is the sum of (1) the prior year adjustment component; and (2) the cumulative adjustment component. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year. As provided under Section 1848(d)(3)(D) of the Social Security Act, the adjustment factor cannot be less than minus 7% or more than plus 3%. Thus, despite calculations which would have led to larger reductions, the UAF adjustment has been minus 7% for the last several years. The caps on the adjustment limit the annual reduction or increase. Thus, the gap between cumulative actual spending and cumulative allowed spending grows larger each year and is exacerbated whenever Congress overrides the reductions, since the targets are never modified under current law.

Historical Updates and Legislative Overrides

Under the update formula, if actual expenditures do not exceed target expenditures, the update generally would be positive and payments would increase for all services under the fee schedule subject to the single conversion factor. In the first few years of the SGR system, the actual expenditures did not exceed the targets. **Figure 1** shows the difference between the cumulative actual allowed (i.e., the target) and cumulative actual expenditures for two different measures of physician services. Prior to 2010, physician services included physician-administered drugs, which resulted in a larger difference between the cumulative targeted expenditures and the cumulative actual. As a consequence, cumulative actual expenditures exceeded the cumulative target expenditures for the first time in the first quarter of 2005 when physician-administered drugs are excluded, as opposed to the second quarter of 2002 when the drugs are included (as shown in **Figure 1**). Under this measure, the updates to the physician fee schedule were close to the MEI in the first two years (2.3% in 1998 and 1999, compared with MEI of 2.2% in 1998 and 2.3% in 1999).[10] For the next two years, in 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years (5.5% update vs. MEI of 2.4% in 2000, 5.0% update vs. MEI of 2.1% in 2001). However, beginning in 2002, the actual expenditures exceeded allowed targets and the discrepancy has grown with each year.

In 2010 and subsequent years, the measurement of physician services was changed to exclude physician-administered drugs. By excluding physician-administered drugs, the difference between actual and targeted expenditures (the solid line in **Figure 1**) is not as large.

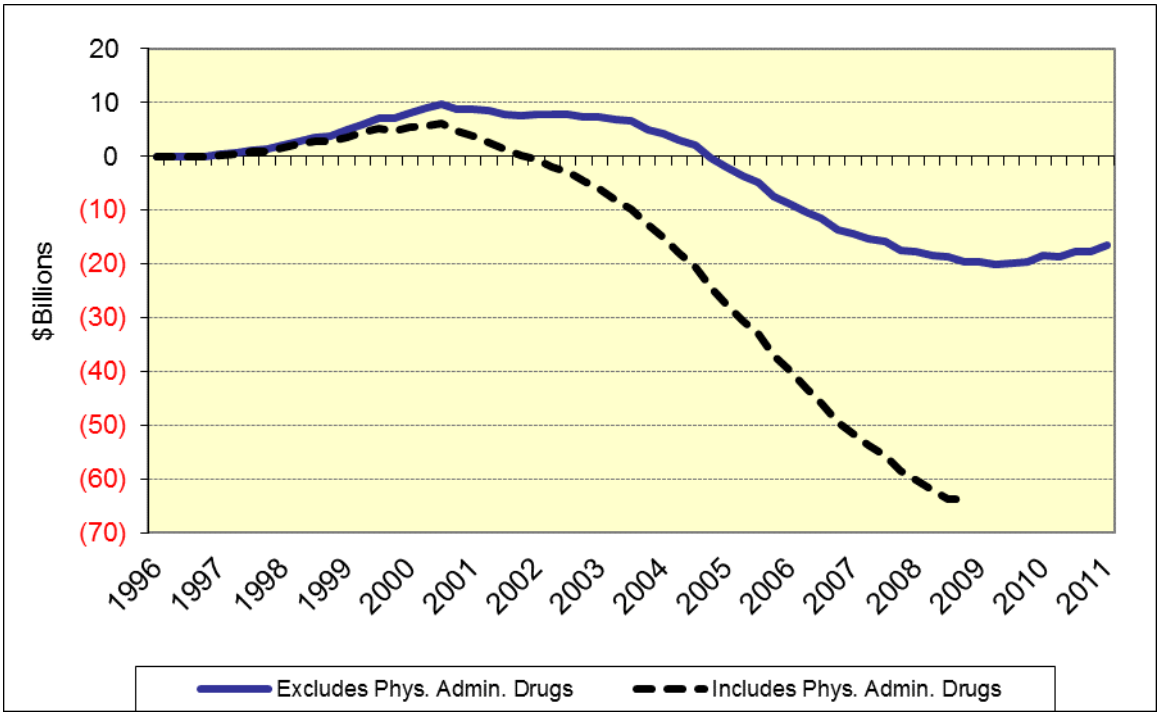
to Part B for CY 2010, Federal Register Notice, November 25, 2009.

[9] Congressional Budget Office, *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies*, June, 16, 2011; http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf.

[10] See Table 6, Actual Past Medicare Economic Index Increases and Physician Updates for 1992−2009, and Estimated Values for 2010, in CMS publication, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010."

Figure 1. Two Measures of the Difference Between Cumulative Allowed and Actual Expenditures for Physician Services Under the SGR System

(1996-2011)



Source: CRS figure from CMS data contained in "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2014." Available at http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2014f.pdf.

Notes: This graph shows the difference between *cumulative* allowed expenditures and actual expenditures for physician services. The figure includes only years for which the data are complete (so estimates or partially complete information for 2012 and 2013 are not included). Beginning in 2010, SGR calculation for 2010 and subsequent years exclude physician-administered drugs. Thus, the estimate for SGR-related expenditures that includes physician-administered drugs is not available after 2009.

The most significant consequence of exceeding the target consistently since 2002 is that the SGR formula dictates a reduction in the physician fee schedule to recoup the overage. However, beginning in 2003, Congress repeatedly passed legislation that has overridden the cuts (see **Table 1**). Greater details about these legislative changes can be found in the **Appendix**.

Despite the change in the measurement of physician services, the consequences of exceeding the target and subsequent legislative overrides would have led to a projected reduction in the conversion factor due to the SGR calculation of 20.1% beginning January 2014.[11] The Pathway for SGR Reform Act (P.L. 113-67) and the Protecting Access to Medicare Act of 2014 (P.L. 113-93) have averted this reduction through March 31, 2015. Congress will need to address the situation again before the end of March 2015 when the override is due to expire.

[11] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/index.html?redirect=/sustainablegratesconfact/.

Table 1. Summary of Updates and Legislative Activity

(2002-2014)

Year	Formula update	Actual update	Legislation	Notes
2002	−4.8%	−4.8%		
2003	−4.4%	1.4%	Consolidated Appropriations Resolution of 2003 (CAR, P.L. 108-7)	The update was 1.7% but was effective on Mar. 1, 2003, so the average update for the year was 1.4%.
2004	−4.5%	1.5%	Medicare Modernization Act of 2003 (MMA, P.L. 108-173)	
2005	−3.3%	1.5%	MMA	
2006	−4.4%	0.2%	Deficit Reduction Act of 2005 (DRA, P.L. 109-171)	Although the DRA froze the conversion factor update, refinements to the RVUs resulted in a 0.2% update for the year.
2007	−5.0%	0%	Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432)	
Jan.-June 2008	−10.1%	0.5%	Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)	Physicians who voluntarily reported on certain quality measures during July 1, 2007-Dec. 31, 2007, were eligible for a bonus payment of 1.5% in 2008 per TRHCA.
July-Dec. 2008	−10.6% reduction from June 2008 level	0% (0.5% from 2007 level)	Medicare Improvement for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)	See above.
2009		1.1%	MIPPA	Physicians who voluntarily reported on certain quality measures during 2008 were eligible for a bonus payment of 1.5% in 2009 per MMSEA.
Jan. 1-Feb. 28, 2010	−21.3%	0%	Department of Defense Appropriations Act (P.L. 111-118)	
Mar. 1-Mar. 31, 2010		0%	Temporary Extension Act (P.L. 111-144)	Signed into law on Mar. 2, 2010.
Apr. 1-May 31, 2010		0%	Continuing Extension Act (P.L. 111-157)	Signed into law on Apr. 15, 2010.

Year	Formula update	Actual update	Legislation	Notes
June 1-Nov. 30, 2010		2.2%	Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192)	Signed into law on June 25, 2010. (Increase was retroactive to June 1.)
Dec. 1-Dec. 31, 2010.		0% (2.2% from Jan.-May, 2010 level)	Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)	
2011		0%	Medicare and Medicaid Extenders Act (P.L. 111-309)	
Jan. 1-Feb. 29, 2012		0%	Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)	
March 1-Dec. 31, 2012		0%	Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)	
2013	−26.5%	0%	American Taxpayer Relief Act (P.L. 112-240)	
Jan. 1-March 31, 2014	−20.1%	0.5%	Pathway for SGR Reform Act of 2013 (P.L. 113-67)	
Apr. 1, 2014-March 31, 2015		0%	Protecting Access to Medicare Act of 2014 (P.L. 113-93)	The 12-month override moves the date of expiration into the 114th Congress.

Source: Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds (several years, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/), and CMS, Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians (several years, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/index.html?redirect=/SustainableGRatesConFact/).

In addition to overriding the payment reductions, Congress has also included provisions in several of the laws to increase Medicare physician payments in other ways. For example, Congress has altered the geographic adjustment factor for physician work, one component used in making regional adjustments to payments under the physician fee schedule. MMA set a floor on the work geographic adjustment index at 1.0 for 2004-2006, thereby slightly increasing the payment amounts in some areas. This floor has been extended multiple times, most recently by the American Taxpayer Relief Act (ATRA, P.L. 112-240), which maintained the floor through 2013, and the Pathway for SGR Reform Act (H.J.Res. 59), which extended the floor through March 31, 2014.

Some of the bills also modified the cap on the conversion factor, which has led to the current situation where the consequence of not overriding the reduction would lead to cuts in excess of

the 7% cap. TRHCA specified that the override of the reduction that would have been implemented under the statutory formula was to be treated as if it did not occur. Therefore, the starting base for the 2008 calculation was 5% below the actual 2007 conversion factor. MMSEA overrode the reduction for the first six months of 2008 and provided for a 0.5% increase for that period. However, the legislation again specified that the override of the statutory formula was to be treated as if it did not occur. MIPPA again specified that the override of the statutory formula was to be treated as if it did not occur.

Issues for Congress: Concerns About SGR

There is a growing consensus among observers that the SGR system is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries.[12] The SGR was developed to restrain the volume growth of Medicare physician services. However, the volume of physician services provided to Medicare beneficiaries continues to grow rapidly, and spending per beneficiary for services covered under the fee schedule has increased faster than both the MEI and updates to the fee schedule's conversion factor.[13] Payment reductions as called for under the update formula have required almost annual interventions by Congress. The following sections discuss briefly some of the key concerns with the SGR.

SGR Does Not Target High Volume Providers or Procedures

One commonly asserted criticism is that the SGR system treats all services and physicians equally in the calculation of the annual payment update to the detriment of physicians who are "unduly" penalized. The expenditure target is a nationwide aggregate and the annual updates are applied uniformly; there is no direct link between individual behavior and the subsequent update. Thus, actions might be individually rational (physicians provide and bill for additional services and collect greater reimbursement) yet collectively detrimental (the annual update is reduced).[14] An individual physician who controls or reduces volume does not see a resulting increase in payments.

Others point out that there is no ability to distinguish between appropriate volume increases (for instance, due to changes in disease conditions that increase demand) and inappropriate volume increases (for instance, when tests or procedures are provided that are not necessary).

Potential Impact on Beneficiary Access to Services

There has been an increased concern that continued declines in physician payment rates, especially among primary care specialties, may potentially jeopardize access to services.[15] The Medicare Payment Advisory Commission's (MedPAC's) annual patient survey of Medicare beneficiaries age 65 and older and privately insured individuals age 50 to 64 found that both of these groups are more likely to report problems finding a new primary care physician compared

[12] MedPAC, Letter to Congress, *Moving Forward from the Sustainable Growth Rate (SGR) System*, October 14, 2011.

[13] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2014, Chapter 4.

[14] Often referred to as the tragedy of the commons: while it may be individually rational for each herder to let livestock graze on the common field (to preserve his own), the collective consequence of many such individual decisions is that the common fields are overgrazed and all herders suffer from the degradation or depletion of the common good.

[15] MedPAC, *Report to Congress: Medicare Payment Policy*, Washington, DC, 2011.

to finding a new specialist. Physician surveys have also found that primary care physicians are less likely than specialists to accept new patients.[16]

Issues for Congress: Potential Modifications and Alternatives

Given the concerns about the SGR, a key issue becomes how to fix or replace the current formula. Although a number of modifications to the SGR system have been proposed, there is no consensus around a long-run alternative. In addition, any permanent change would likely be quite costly because the CBO baseline must assume current law, which estimates that a reduction in the conversion factor will occur for the next several years. In addition to the impact on federal outlays, any change in the update formula will also have implications for beneficiaries; because Part B beneficiary premiums must cover about 25% of Part B program costs, any overall increase in spending results in a proportional increase in premiums.[17] Suggested modifications have ranged from modifying the current formula to replacing the formula and linking updates to payment adequacy and/or quality measures.

The Medicare Modernization Act of 2003 (MMA) required that GAO study "the appropriateness of the sustainable growth rate formula" and "the stability and predictability of such updates and rate and alternatives."[18] In a 2004 report, the GAO categorized options for alternatives around two themes: (1) proposals that end the use of spending targets and separate fee updates from explicit efforts to moderate spending growth; and (2) proposals that retain spending targets but modify the current SGR system to address perceived shortcomings.[19] The first approach emphasizes stable fee updates, while the second automatically adjusts fee updates if spending growth deviates from a predetermined target. GAO stated that "the choice between the two approaches may hinge on whether primary consideration should be given to stable fee increases or to the need for fiscal discipline within the Medicare program."[20] The second approach would end targets as an explicit measure for moderating spending growth. Updates would be based on cost increases with the possibility of specifically addressing high volume service categories such as medical imaging.

Legislative Proposals Introduced to Repeal or Modify the SGR

For illustrative purposes, **Table 2** shows several legislative proposals introduced, but never (or not yet) enacted, that would have changed the way SGR is calculated. While both proposals would replace the current system of a single expenditure target with multiple targets, the key difference between them is the number of targets. Providing separate targets attempts to address, among other things, the criticism that the current update calculation penalized (or rewarded) all physicians identically regardless of the individual's or the specialty's contribution towards meeting or exceeding the aggregate expenditure target. Some physicians and health care professionals are able to increase volume to offset declining reimbursement rates while others are

[16] 2009 Ambulatory Medical Care Survey.

[17] For details on Medicare Part B premiums see CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

[18] P.L. 108-173, §953(a).

[19] U.S. Government Accountability Office, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO-05-85, October 8, 2004.

[20] Ibid.

not. For example, even though imaging services have grown faster than other types of physician services (including evaluation and management services, tests, major procedures, and other procedures) the resulting impact on the annual update factor applies to all services across all specialties.

As shown in **Table 2**, H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP), was introduced in the 110th Congress and includes six expenditure targets. Some have raised concern that too many expenditure targets may not be appropriate since the targets do not distinguish between the appropriateness of certain services. For example, some of the increase in imaging services may have allowed for the earlier detection of disease conditions such as cancer, which may have produced savings for other services and specialties (e.g., nuclear medicine and oncology services). Thus, the second approach in H.R. 3961, the Medicare Physician Payment Reform Act of 2009 (111th Congress), would only have had two expenditure categories: (1) evaluation, management, and preventive services; and (2) all other services. This approach would distinguish between primary care and non-primary care services and would be similar to the MedPAC proposal discussed below. One rationale for this approach is to improve access to primary care providers. As noted earlier, the greatest threat to access over the next decade is concentrated in primary care services.[21]

Table 2. Select Legislative Proposals to Modify the SGR Calculation

Legislative Proposal	Bill Summary
H.R. 3162 (110th Congress) **The Children's Health and Medicare Protection Act of 2007**	Section 301 of Title III would have modified the SGR system by: Replacing single conversion factor and target growth rates with six newly created service categories: • evaluation and management services for primary care and for preventive services; • other evaluation and management services; • imaging services and diagnostic tests; • major procedures; • anesthesia services; and • minor procedures and other services. The proposal included the following exceptions to current SGR methodology: • "physicians' services" would refer to the physicians' services included in the appropriate service category, • the estimate of the annual average percentage growth in real gross domestic product per capita for the applicable period would have been increased by 0.03, and • a national coverage determination would be treated as a change in regulation and thus incorporated into the Secretary's estimate of the percentage change in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) resulting from changes in law and regulations. The provision would have established a floor for updates so that the conversion factors for each service category would be no less than 0.5% for 2008 and 2009.

[21] MedPAC, *2011 Report To Congress: Medicare Payment Policy*.

Legislative Proposal	Bill Summary
H.R. 3961 (111th Congress) **The Medicare Physician Payment Reform Act of 2009**	Similar to H.R. 3162, but different in the following manner: First, the bill would create two (rather than six) categories of physician services, each with its own separate target growth rate and conversion factor update. The two categories of service would be (1) evaluation, management, and preventive services; and (2) all other services. Target expenditures for the evaluation, management, and preventive services category would be allowed to grow at the rate of growth of per capita GDP plus 2%, while the target expenditures for the all other category would be allowed to grow at the rate of growth of per capita GDP plus 1%. The proposal would establish a new baseline year for calculating expenditure targets for each category. Only physician services would be included in the calculation of actual and target growth expenditures; services provided incident to the physician visit (such as laboratory services), would not be included. During the transition to the calculations required for the new method of calculating targets and updates, the 2010 update would be the percentage increase in the Medicare economic index (MEI). In its final rule for 2010 Medicare physician payments, CMS specified that the MEI will be 1.2%.
H.R. 2810 (113th Congress) **The Medicare Patient Access and Quality Improvement Act of 2013** **– Energy & Commerce** **– Ways & Means** **S. 1871 (113th Congress)** **The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013**	While there are differences between the three bills, they share the following concepts: (1) each bill would provide an initial period of payment stability: H.R. 2810 would increase MPFS payments by 0.5% each year from 2014-2018, S. 1871 would freeze the payments (0% increase) for ten years from 2014-2023, and H.R. 2810 would increase payments by 0.5% in 2015 and 2016, (2) each would establish the development of new payment systems while maintaining fee-for-service payment in a manner similar to the existing system, and (3) each would create incentives for physicians to transition to the new payment systems over time, generally by establishing different rates of increase over time for the new payment systems compared to fee-for-service.
H.R. 4015/S. 2000 (113th Congress) **The SGR Repeal and Medicare Provider Payment Modernization Act of 2014**	Payment updates would be the following: • 5 years of 0.5% payment increases • 5 years of 0% payment increases • updates determined by many factors, including participation in alternative payment models and provider performance in the newly created Merit-Based Incentive Payment System (MIPS). MIPS would subsume some of the current physician payment incentives (e.g., the meaningful use criteria for electronic health records and the value-based payment modifier) while others would be sunset (e.g., certain quality reporting incentives).

Source: Compiled by the Congressional Research Service based on information derived from the Legislative Information System.

Most proposed changes to the SGR would also change the base year in the calculation of future expenditure targets (essentially starting over), which could increase overall physician

expenditures allowed in the baseline. One issue to consider with any proposals that increase total spending on physician services (by rebasing and changing the expenditure targets) is that the impact of the proposal would be felt not only by physicians but also by other parts of the Medicare program, the Department of Defense TRICARE program, and beneficiaries under Medicare Part B. Not only would physician reimbursements under the Medicare physician fee schedule increase, but expenditures under the Medicare Advantage (MA) program would increase because per beneficiary spending for fee-for-service beneficiaries would increase as a result of the bill, raising the "benchmarks" that Medicare uses to determine the capitation payments for beneficiaries enrolled in Medicare Advantage plans. TRICARE expenditures would rise because its physician reimbursements are based on Medicare's physician fee schedule. Furthermore, since Medicare Part B beneficiary premiums are required to cover about 25% of total Part B expenditures, the increases in physician reimbursements as a result of changing the update calculation would put pressure on future Part B premiums to rise.

MedPAC Proposals

The Deficit Reduction Act of 2005 (DRA) required MedPAC to submit a report to Congress on mechanisms that could be used to replace the SGR system, including "such recommendations on alternative mechanisms to replace the sustainable growth rate system as the Medicare Payment Advisory Commission determines appropriate."[22] In its March 2007 report, MedPAC described two possible paths: one path would eliminate the SGR and emphasize the development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care, while the second path would add a new system of expenditure targets in addition to these approaches.[23] Earlier reports to Congress from MedPAC have included recommendations for updating payments for physicians' services based on the estimated change in input prices for the coming year less an adjustment for savings attributable to increased productivity. Specifically, input prices would be measured using the MEI (without regard to the CMS adjustment for productivity increases). The recommended productivity adjustment would be used across all provider services.[24]

On several occasions, MedPAC has sent to Congress specific recommendations for addressing the SGR and Medicare physician payments. The recommendations acknowledge the criticisms of the SGR system as well as the concern that beneficiary access to providers willing to accept Medicare patients may be affected in coming years should the uncertainty about fee schedule reimbursements continue. Further, MedPAC has been concerned about reducing the discrepancy in payment between primary care services (mostly cognitive, evaluation, and management activities) and specialty care and procedure-oriented services.

MedPAC's October 14, 2011, recommendations to Congress were to (1) freeze the Medicare physician fee schedule reimbursement rates for primary care services for 10 years; (2) reduce non-primary care fee schedule reimbursements by 5.9% each year for three years, then freeze the rates at that level for 7 additional years; and (3) offset about $200 billion of the cost of the override as proposed through a combination of other modifications to the Medicare program.[25]

[22] P.L. 109-171, §5104(c).

[23] MedPAC, *Assessing Alternatives to the Sustainable Growth Rate System*, March 2007.

[24] MedPAC, *Report to the Congress, Medicare Payment Policy*, March 2008.

[25] There was no CBO score for this proposal since it was a MedPAC initiative that included scenarios not previously scored by CBO. For details, see http://www.medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.

The primary care services subject to the reimbursement freeze would be determined in a manner similar to the eligibility criteria for the primary care bonus introduced by the Patient Protection and Affordable Care Act (ACA):[26] providers would have to (1) be a physician whose self-declared specialty is in one of the primary care specialties (family medicine, internal medicine, geriatric medicine, or pediatric medicine) or be a nurse practitioner, clinical nurse specialist, or physician assistant; and (2) furnish 60% of their services in the primary care service codes (office visits, home visits, and visits to patients in nursing facilities, domiciliaries, and rest homes). The freeze on reimbursement rates for primary care services would apply only to those service codes. Thus, a primary care provider could provide some services where the reimbursement rates would be frozen as a result of the MedPAC proposal and other services where the reimbursement rates would be subject to a decrease. Similarly, two different physicians could bill for the same code, yet one could be paid at the frozen reimbursement rate while the other would be paid at a reduced rate. MedPAC projects that even with this combination of freezes and reductions to the fee schedule reimbursements, total Medicare expenditures per beneficiary for fee schedule services will continue to rise over the next 10 years.

MedPAC's prior recommendations to Congress have included development of additional initiatives to (1) collect data to improve payment accuracy, (2) identify overpriced services, and (3) encourage and accelerate the development of alternative payment models (e.g., bundled payments).[27]

Physician Payments and Patient Protection and Affordable Care Act (ACA)

If the SGR system is abandoned, a key question becomes what is the best payment system to replace it that would lead to improvements in quality, efficiency, and care coordination, particularly for chronic conditions. As noted above, MedPAC recommended exploring the feasibility of Medicare Accountable Care Organizations (ACO) and bundling of payments.[28]

The ACA included a number of demonstrations and other efforts aimed at alternative payment models that have the potential to change fundamental aspects of how physicians organize, practice, and deliver care in the future.[29] Some of these provisions create new structures and entities, like the CMS Center for Medicare and Medicaid Innovation or the Patient-Centered Outcomes Research Institute (PCORI), while others seek to develop alternatives to traditional fee-for-service payment, such as the National Pilot Program on Payment Bundling, the Medicare-shared savings program (including the ACO model), or the value-based payment modifier under the physician fee schedule. The PCORI, combined with the efforts and experiences with the alternative payment models, could generate new information about how alternative treatments affect patient outcomes as well as evidence to support how different payment methods might alter the incentives for providers and the outcomes for patients. The Innovation Center has the authority and flexibility to adopt new payment alternatives, so long as certain criteria are met—for instance, maintaining quality while reducing expenditures, or improving quality without increasing expenditures. Although these various initiatives have the potential to modify behavior

[26] See §5501 of the Patient Protection and Affordable Care Act (P.L. 111-148).

[27] MedPAC, *Assessing Alternatives to the Sustainable Growth Rate System*, March 2007.

[28] See CRS Report CRS Report R41474, *Accountable Care Organizations and the Medicare Shared Savings Program*.

[29] The following information is derived from CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

and payments for physicians and related providers, none have yet produced concrete findings or recommendations on which to base fundamental changes in Medicare physician payments.

Budgetary Implications of Repealing or Changing the SGR Formula

Repealing or fixing the SGR could be costly from a federal budgetary perspective, although recent CBO estimates of replacement proposals have fluctuated. In July 2012, CBO issued cost estimates for a variety of approaches for dealing with the physician payment issue. They estimated that a one-year fix to the SGR allowing physician payments to remain the same as the prior year would cost about $11.1 billion in FY2013 and $18.5 billion over 10 years (2013-2022) with a cliff option (see discussion above). However, longer-term fixes would be more costly. According to CBO, freezing payments for a 10-year period would cost a total of approximately $273.3 billion and increasing payments by the MEI each year through 2022 would increase federal spending by about $362 billion for the FY2013-FY2022 period.[30] Coupling any of these options with a provision to exclude this change from beneficiary premium calculations ("premium hold-harmless") would increase federal spending even further over the same period.

On February 5, 2013, CBO released a report stating that its estimate of the cost of overriding the SGR with a 10-year freeze in payments had fallen by more than $100 billion over 10 years compared to its July 2012 estimate of $273.3 billion (see above). The cost of "holding payment rates through 2023 at the levels they are now would raise outlays for Medicare (net of premiums paid by beneficiaries) by $14 billion in 2014 and about $138 billion (or about 2 percent) between 2014 and 2023." CBO provided the following reasoning for the reduced cost:

> The estimated cost of holding payment rates constant is much lower relative to this baseline than was the case under previous CBO baselines, primarily because of lower spending for physicians' services in recent years. Under the sustainable growth rate, future payment updates depend on the difference between spending in prior years and spending targets established in law. Actual spending has been lower than projected—and lower than the spending targets inherent in the sustainable growth rate—for the past three years. Because actual spending has been lower than spending targets, CBO now estimates that payment rates will increase beginning in 2015. Those higher payment rates narrow the difference between growth under current law and a freeze at current levels, thereby reducing the estimated cost of restricting the payment rates. [31]

CBO's May 2013 baseline projections raised the estimate slightly to $139.1 billion for a 10-year freeze.[32] In December 2013, CBO issued another score indicating that a 10-year freeze in MPFS payment levels would add $116.5 billion over 10 years.[33] On April 11, 2014, CBO released a score of $124 billion for a 10-year freeze in Medicare physician fee schedule payments.[34] CBO did not include any text explaining the fluctuations in scoring since the February 5, 2013, scoring but changes likely reflect general fluctuations in health care spending in the most recent data.

[30] Congressional Budget Office, *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline*. July 2012. http://cbo.gov/sites/default/files/cbofiles/attachments/43502-SGR%20Options2012.pdf.

[31] CBO, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023,* February 2013, p. 31.

[32] http://cbo.gov/sites/default/files/cbofiles/attachments/44184_May_2013_SGR.pdf.

[33] http://www.cbo.gov/publication/44940.

[34] See CBO, "Budgetary Effects of Selected Policy Alternatives not included in CBO's Baseline" http://www.cbo.gov/publication/45252.

Current Status and Recent Activity

Several congressional actions have overridden the SGR update in the 112th and 113th Congresses. On December 17, 2011, the Senate passed an amended version of H.R. 3630 that included a two-month override of the SGR payment reduction through February 2012, freezing reimbursement rates at 2011 levels. Beginning March 2012 and in subsequent years, the calculation of the fee schedule reimbursement rates would revert to the statutory formula. On December 20, 2011, the House voted to resolve differences between the two versions of the bill, and the Speaker appointed conferees for a conference committee.

On December 23, 2011, H.R. 3765, which contained a two-month override to the SGR payment reduction through February 2012, was introduced and passed by unanimous consent in both the House and the Senate and was signed into law that day.

On February 16, 2012, House and Senate conferees came to an agreement on a conference report for the Middle Class Tax Relief and Job Creation Act (P.L. 112-96) that extended the override through December 31, 2012, and maintained Medicare physician fee schedule payments at the same level. CBO scored this provision as increasing spending by $18 billion over 10 years (2012-2022).[35]

On January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). This act was passed by the Senate on January 1, 2013, by a vote of 89-8 and by the House later that day, 257-167. Section 601 of the act averted the SGR-determined reduction and maintained the Medicare physician fee schedule payments at then-current rates through December 31, 2013.

Each of the three committees of jurisdiction passed bills in 2013 that would repeal the SGR system (see **Table 2**). On July 22, 2013, the Energy and Commerce Committee passed H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013,[36] by a 51-0 vote. On December 12, 2013, the Senate Finance Committee passed S. 1871, the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013,[37] by unanimous voice vote, and the Ways and Means Committee passed H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013.[38]

While there are differences among the three bills, they share several overarching concepts. First, each of the bills would provide an initial period of payment stability: the Energy and Commerce bill would increase MPFS payments by 0.5% each year from 2014 to 2018, the Senate Finance Committee bill would freeze the payments (0% increase) for 10 years from 2014 to 2023, and the Ways and Means bill would increase payments by 0.5% in 2015 and 2016.[39] Second, they each establish the development of new payment systems while maintaining fee-for-service payment in a manner similar to the existing system. Third, they each create incentives for physicians to transition to the new payment systems over time, generally by establishing different rates of increase over time for the new payment systems compared to fee-for-service. The bills also vary in which non-SGR provisions are included; S. 1871 includes several health care and human

[35] For details, see http://cbo.gov/ftpdocs/127xx/doc12764/hr3630.pdf.

[36] http://docs.house.gov/meetings/IF/IF14/20130722/101205/BILLS-113DiscussionDraftpih-DiscussionDraft.pdf.

[37] http://www.finance.senate.gov/legislation/details/?id=a275e061-5056-a032-5209-f4613a18da1b.

[38] On January 24, 2014, the CBO scored H.R. 2810 at $121 billion over 10 years.

[39] The Pathway for SGR Reform Act of 2013 increased payments by 0.5% for January 1, 2014, through March 31, 2014.

service program extenders (including the Medicare, Medicaid, and CHIP programs), while H.R. 2810 as reported by the Energy and Commerce Committee includes provisions that would modify evidentiary rules and practices regarding medical malpractice claims. None of these bills include budgetary offsets.

The CBO scores for each of the three bills reflect a range of costs, with Title I of the Senate bill (dealing with the SGR) adding $111.5 billion[40] to direct federal spending from 2014 to 2023, while H.R. 2810 as considered by the Ways and Means Committee would add $121 billion.[41] CBO initially scored H.R. 2810 as reported by the Energy and Commerce Committee as adding $175 billion[42] over the same period, but revised the figure to $146 billion, reflecting subsequently enacted legislation as well as modifications specified in the physician fee schedule final rule for 2014.

On December 26, 2013, the President signed into law H.J.Res. 59, which included the Bipartisan Budget Act of 2013 (Division A) and the Pathway for SGR Reform Act of 2013 (Division B). Section 1101 of the Pathway for SGR Reform Act provided for a 0.5% increase in MPFS payments for three months, from January 1, 2014, through March 31, 2014.

On February 6, 2014, H.R. 4015 and S. 2000, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, were introduced in the House and Senate, respectively.[43] H.R. 4015/S. 2000 propose five years of 0.5% payment increases for the Medicare physician fee schedule before freezing payments at that level for five additional years. Changes to the payment level in subsequent years would be determined by many factors, including participation in alternative payment models and provider performance in the newly created Merit-Based Incentive Payment System (MIPS) for those who choose to remain in the fee-for-service payment system. MIPS would subsume some of the current physician payment incentives (e.g., the meaningful use criteria for electronic health records and the value-based payment modifier), while others would be sunset (e.g., certain quality reporting incentives). As an incentive for providers to choose to participate in alternate payment models, payment rate increases would be greater for APMs (1.0% per year beginning in 2024) than for the FFS/MIPS system (0.5% per year beginning in 2024). CBO has scored these identical bills as adding $138.4 billion to direct spending from 2014 to 2024 (11 years, rather than the typical 10).

On March 14, 2014, the House passed H.R. 4015, with an amendment submitted by Chairman Camp. The amendment would delay the individual mandate penalty under the ACA for five years.[44] The CBO scored the amended version of H.R. 4015 as reducing direct federal spending by $31.1 billion over the 11 years from 2014 to 2024, as the delay of the individual mandate

[40] Including the health care program extenders and other provisions in Title II of the bill would result in an aggregate score of $150.4 billion for the entire bill, http://www.cbo.gov/publication/45045.

[41] http://www.cbo.gov/publication/45040.

[42] http://www.cbo.gov/publication/44578.

[43] H.R. 4015 is more detailed than either of the versions of H.R. 2810 reported by the Energy & Commerce or the Ways & Means Committees. In addition to the SGR repeal, H.R. 4015 contains sections addressing quality measure development, care management for beneficiaries with chronic care needs, ensuring accurate valuation of services under the physician fee schedule, expanding the availability of Medicare data, and other issues. S. 2000 is more detailed than S. 1871 with respect to the repeal of the SGR and the proposed replacements, but does not include any of the health care program extenders that were present in S. 1871.

[44] For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under ACA*, by Annie L. Mach.

penalty would reduce spending by $169.5 billion, more than offsetting the direct cost of the SGR repeal and replace provisions.

P.L. 113-82,[45] signed into law on February 15, 2014, created a new Transitional Fund for Sustainable Growth Rate Reform (and, in the process, eliminates the Medicare Improvement Fund). Amounts in the SGR reform fund are to "be available to the Secretary to provide funds to pay for physicians' services under part B to supplement the conversion factor [...] for 2017 if the conversion factor for 2017 is less than conversion factor for 2013." During or after 2017, $2.3 billion is to be available to the fund from the Federal Supplementary Medical Insurance (Part B) Trust Fund. How and whether these funds are used remains to be seen; however, the amount specified in statute falls short of recent CBO estimates of the cost of a one-year freeze in payment levels.

On April 1, 2014, the Protecting Access to Medicare Act (PAMA, P.L. 113-93) was signed into law. The PAMA provided a 12-month override of the SGR-directed payment reduction and keeps Medicare physician fee schedule payments at the current level through March 31, 2015. The PAMA also included several health program extenders.

[45] The fund was created by Section 3 of this act, titled, "An act to ensure that the reduced annual cost-of-living adjustment to the retired pay of members and former members of the Armed Forces under the age of 62 required by the Bipartisan Budget Act of 2013 will not apply to members or former members who first became members prior to January 1, 2014, and for other purposes."

Appendix. Recent SGR Legislative Activity Enacted into Law

Department of Defense Appropriations Act, 2010 (P.L. 111-118)

Summary

On December 16, 2009, the House passed H.R. 3326, the FY2010 Defense Appropriations bill. One of the provisions in Section 1011 of the bill delayed the application of the update to the conversion factor until February 28, 2010.[46] Another provision in the same section reduced the amount of monies available in the Medicare Improvement Fund by $1.55 billion.[47] The Senate passed the bill on December 19, 2009,[48] and the bill was signed into law[49] that day.

Brief Analysis

The bill delayed the payment reductions from taking effect for two months while maintaining fee schedule reimbursements at 2009 levels.

Increasing the Statutory Limit on the Public Debt (P.L. 111-139)

Summary

Section 7 of Title I of this bill (H.J.Res. 45, the Statutory Pay-As-You-Go Act of 2010), which was signed into law on February 12, 2010 (P.L. 111-139), provides a limited exception to the PAYGO rules for addressing the Medicare physician payment situation as a result of the SGR system (as well as additional exceptions). The maximum amount of the exception is to be the difference between estimated net outlays if 2009 Medicare fee schedule payment rates were to be in effect for the next five years (i.e., a "freeze" through December 31, 2014) and what the payments would have been had fees reverted to levels as dictated under the SGR system. Furthermore, any future legislation that reforms or replaces the SGR system would be scored for PAYGO purposes only if the modification were to cost more than the cost of the five-year freeze at 2009 levels. If legislation changing the SGR system were to be enacted that costs less than the five-year freeze through 2014, any remaining amount in the adjustment could be used to offset costs after 2014 as a result of the change, but the total adjustment could not exceed the maximum adjustment amount.

[46] For roll call details, see http://clerk.house.gov/cgi-bin/vote.asp?year=2009&rollnumber=985.

[47] §188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries.

[48] For roll call details, see http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00384.

[49] P.L. 111-118.

Brief Analysis

The provision exempts the equivalent of a five-year freeze of Medicare reimbursement at 2009 levels from PAYGO—an amount CBO estimates to be $88.5 billion.[50] Congress would still have to pass legislation that would override the cuts as directed by the SGR system.

Temporary Extension Act of 2010 (P.L. 111-144)

Summary

On February 25, 2010, the House passed H.R. 4691, the Temporary Extension Act of 2010, by voice vote. This bill extended a number of expiring programs, including unemployment insurance benefits, premium assistance for COBRA benefits, and the Medicare therapy caps, in addition to forestalling the Medicare physician payment cuts. Section 5 modified the Defense Appropriations Act, 2010, by delaying the payment reduction for another month, through March 31, 2010. The CBO score for this section is $1.04 billion in additional outlays.[51] Although a motion to pass the bill by unanimous consent failed in the Senate that evening,[52] the bill eventually passed the Senate by a vote of 78-19[53] and was signed into law (P.L. 111-144) on March 2, 2010.

Brief Analysis

This bill delayed the payment reductions from taking effect until April 1, 2010, while maintaining fee schedule reimbursements at 2009 levels through March 31, 2010.

Statutory Pay-As-You Go Act of 2010 (Title I of P.L. 111-139)

Summary

The Statutory Pay-As-You Go Act of 2010 (Title I of P.L. 111-139) established a new budget enforcement mechanism generally requiring that direct spending and revenue legislation enacted into law not increase the deficit.[54] However, changes to the SGR that resulted in increased spending were to be considered a limited exception to that rule if enacted before January 1, 2012. Furthermore, the maximum amount of the exception was to be the difference between estimated net outlays if 2009 Medicare fee schedule payment rates had been in effect for the next five years (i.e., a "freeze" through December 31, 2014) and what the payments would have been had fees reverted to levels as dictated under the SGR system. In addition, any legislation that reformed or replaced the SGR system would be scored for pay-as-you-go (PAYGO) purposes only if the modification were to cost more than the cost of the five-year freeze at 2009 levels.

[50] http://www.cbo.gov/budget/factsheets/2010b/SGR-menu.pdf.

[51] CBO score available at http://www.cq.com/displayfile.do?docid=3299370.

[52] See the Congressional Record at http://thomas.loc.gov/cgi-bin/query/B?r111:@FIELD(FLD003+s)+@FIELD(DDATE+20100225.

[53] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=2&vote=00032.

[54] See CRS Report R41157, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, by Bill Heniff Jr.

Brief Analysis

No bills were ever passed into law that satisfied the conditions of this act.

Continuing Extension Act of 2010 (P.L. 111-157)

Summary

On March 17, 2010, by voice vote, the House passed H.R. 4851, as amended (striking all after the enacting clause and inserting new text). The bill includes extensions for several programs, including certain unemployment insurance provisions, premium assistance for COBRA benefits, and the Medicare therapy caps exceptions process in addition to forestalling the SGR payment reductions for another month, until May 1, 2010. The Senate amended Section 4 of the bill by lengthening the Medicare physician payment cut extension until May 31, 2010, and both houses of Congress passed the bill on April 15, 2010. The President signed the bill into law (P.L. 111-157) that day.

Brief Analysis

The bill delayed the physician payment reductions from taking effect until June 1, 2010, while maintaining fee schedule reimbursements at 2009 levels through May 31, 2010.

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (P.L. 111-192)

Summary

On June 18, 2010, more than two weeks after the May 31, 2010, expiration of the extension under the Continuing Extension Act of 2010,[55] the Senate passed an amended version of H.R. 3962 by voice vote that averted the SGR-determined payment reduction and increase the conversion factor by 2.2% retroactive to June 1, 2010, and continuing through November 30, 2010. CBO scored this provision as adding $6.3 billion to direct spending over the 5- and 10-year budget window, with all spending occurring in fiscal years 2010 and 2011. The cost is offset (1) by imposing a three-day prohibition on hospital provision that would bar Medicare contractors from reopening or adjusting claims by hospitals during the three days preceding a patient's inpatient admission, and (2) from savings resulting from modifications that allow firms to spread out their pension fund obligations over a longer period, resulting in fewer tax-preferred contributions to pension plans and creating more taxable income for the firms.

The House passed the Senate-amended bill on June 24, 2010.[56] The President signed the bill into law (P.L. 111-192) the next day.

[55] CMS issued two instructions to its contractors regarding claims affected by the expiration. The first, on May 27, instructed contractors to hold claims for services dated June 1 and later and paid under the Medicare physician fee schedule for the first 10 business days of June (i.e., through June 14, 2010). The second, on June 18, 2010, instructed contractors to begin lifting the hold and to begin processing June 1 and later Medicare physician fee schedule claims under the law's negative update requirement on a first-in/first-out basis.

[56] The vote was 417-1, with 14 Members not voting. See http://clerk.house.gov/evs/2010/roll393.xml.

Brief Analysis

The act increases the Medicare physician fee schedule payments by 2.2% for six months. A substantial payment reduction (about 23%) would have been required beginning December 1, 2010, and an additional reduction (about 6%) would have been applied beginning January 1, 2011, in the absence of further congressional action.

The Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)

Summary

On November 18, 2010, by unanimous consent, the Senate passed H.R. 5712,[57] which extended the 2.2% increase established by P.L. 111-192 (discussed above) for an additional month through December 31, 2010. The House passed the amended bill on November 29, 2010, by voice vote, and the President signed the bill into law (P.L. 111-286) on November 30, 2010.

The cost of the override was offset by reductions to payments to providers for the second and for additional services when multiple therapy procedures are performed on the same patient on the same day.[58]

Brief Analysis

While this extension maintained provider payments at the existing level, additional legislative action was required to forestall the reduction to payments under the Medicare fee schedule that would have taken effect beginning January 1, 2011.

Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)

Summary

The Medicare and Medicaid Extenders Act of 2010 (H.R. 4994) extended many Medicare provisions that were due to expire on December 31, 2010, and made other changes to the Medicare and Medicaid program, including a one-year override of the payment reductions required under the SGR system. This act provided for a 0% update adjustment factor in 2011 compared to the (end-of-year) 2010 payments. These provisions were fully offset.[59]

[57] Originally introduced in the House in July 2010 as the Veterans', Seniors', and Children's Health Technical Corrections Act of 2010, the version passed by the Senate struck and substituted everything after the enacting clause. in addition to the physician payment modification, the bill also modified the discount applied to payments for therapy services when multiple procedures are performed on a beneficiary on the same day.

[58] See Congressional Budget Office, Estimate of the Statutory Pay-As-You-Go Effects for the Physician Payment and Therapy Relief Act of 2010, November 18, 2010, http://cbo.gov/ftpdocs/119xx/doc11969/PhysicianPaymentandTherapyReliefAct.pdf.

[59] The one-year override was offset by increasing the penalties collected from individuals who improperly receive health insurance tax credits (under health care reform), replacing the two fixed penalty amounts ($250 for individuals and $400 for families at or below 400% of the federal poverty level) with a scaled penalty related to income. The CBO score is available at http://cbo.gov/ftpdocs/120xx/doc12008/hr4994.pdf.

Brief Analysis

Following the one-year override, the legislation states that "the conversion factor ... shall be computed ... for 2012 and subsequent years as if [the override] had never applied." CMS's November 2011 estimate of the 2012 SGR[60] is that a 27.4% reduction will be required beginning January 1, 2012, in the absence of further legislative action.[61] In its March 2011 report, MedPAC recommended a 1% update to the Medicare physician fee schedule for 2012.[62]

Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)

Summary

On December 23, 2011, H.R. 3765, which contained a two-month override through February 2012, was passed by both the House and the Senate by unanimous consent and was signed into law (P.L. 112-78).

Brief Analysis

Physician fee schedule payments were extended at the 2011 level for January and February 2012.

Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)

Summary

On February 16, 2012, House and Senate conferees came to an agreement on a conference report for H.R. 3630 that extended the override through December 31, 2012 (P.L. 112-96), maintaining physician fee schedule payments at the current level.

Brief Analysis

In the absence of an override, the physician fee schedule payments would have been reduced by 27% beginning January 2013.

American Taxpayer Relief Act of 2012 (P.L. 112-240)

Summary

On January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). This act was passed by the Senate on January 1, 2013, by a vote of 89-8,[63] and by the House later that day, 257-167.[64] Title VI of the act extends several expiring provisions

[60] The Secretary is required (§1848(d)(1)(E) of the Social Security Act) to make public an estimate of the sustainable growth rate (SGR) and the conversion factor applicable to Medicare payments for physicians' services for the following year by March 1 of each year.

[61] Centers for Medicare & Medicaid Services, Press Release, *CMS Announces Policy, Payment Rate Changes for the Physician Fee Schedule in 2012*, November 1, 2011.

[62] MedPAC, *Report to the Congress: Medicare Payment Policy*, Washington, DC, March 2011, http://www.medpac.gov/documents/mar11_entirereport.pdf.

[63] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=112&session=2&vote=00251.

[64] http://clerk.house.gov/evs/2013/roll659.xml.

in the Medicare and Medicaid programs and makes other changes in federally funded health programs. Many of the sections in Title VI of the ATRA extend current law provisions, resulting in higher Medicare provider payments or extending authorization and/or funding for expiring programs. In particular, Section 601 in Title VI of ATRA overrides the sustainable growth rate (SGR) update mechanism of the Medicare physician fee schedule that would have reduced payments had it taken effect and extends payments at the current level through December 31, 2013.

Brief Analysis

The override averted a 26.5% reduction in Medicare Physician Fee Schedule payments that would have applied had ATRA not passed.

Pathway for SGR Reform Act of 2013 (H.J.Res. 59; P.L. 113-67)

Summary

Division B of H.J.Res. 59, the Pathway for SGR Reform Act of 2013, included a provision that overrode the SGR-mandated reduction and increased the MPFS payments by 0.5% from January 1 through March 31, 2014.[65]

Brief Analysis

The override averted a 20.1% reduction in MPFS payments. The CBO score for the 3-month override was $7.1 billion over the 5-year period 2014-2018 and $7.3 billion over the 10-year period 2014-2023.[66] Absent additional congressional action, the SGR-mandated payment reductions would take effect beginning April 1, 2014.

S. 25; P.L. 113-82

Summary

On February 15, 2014, an amended version of S. 25 was signed into law by the President, after having passed the House[67] on February 11, 2014, and the Senate[68] on February 12, 2014. Section 3 of P.L. 113-82, entitled "An Act to ensure that the reduced annual cost-of-living adjustment to the retired pay of members and former members of the Armed Forces under the age of 62 required by the Bipartisan Budget Act of 2013 will not apply to members or former members who first became members prior to January 1, 2014, and for other purposes," eliminates the Medicare Improvement Fund and creates the "Transitional Fund for Sustainable Growth Rate (SGR) Reform." During or after 2017, $2.3 billion are to be made available from the Federal Supplementary Medical Insurance (Part B) Trust Fund "to pay for physicians' services under Part B to supplement the conversion factor under [SSA] section 1848(d) for 2017 if the conversion factor for 2017 is less than conversion factor for 2013."

[65] Other sections of the act extended certain expiring Medicare and other health program provisions.

[66] http://cbo.gov/publication/44965.

[67] http://clerk.house.gov/evs/2014/roll060.xml.

[68] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=2&vote=00035.

Brief Analysis

While the resources ($2.3 billion) in the fund are to be available "during or after 2017," the statutes establishing the SGR and related formulas remain intact as of the passage and signing into law of P.L. 113-82. Neither the SGR repeal and replacement bills in the House nor the Senate have been considered on either floor as of the date of enactment of P.L. 113-82.

Protecting Access to Medicare Act of 2014 (PAMA,P.L. 113-93)

Summary

On April 1, 2014, H.R. 4302, the Protecting Access to Medicare Act of 2014, was signed into law (P.L. 113-93). The Senate passed the bill on March 31, 2014,[69] after the House passed the bill on March 27, 2014, by voice vote.[70] The PAMA maintains Medicare physician fee schedule payments at the existing level for an additional 12 months, from April 1, 2014, through March 31, 2015. In addition to the SGR override, the PAMA also contains several health program extenders.

Brief Analysis

Prior to the passage of the PAMA, which extended the current payment level override for a full year (through March 31, 2015), an alternate proposal that extended the override for only nine months (through the end of the 2014 calendar year) was proposed. A patch that expired at the end of the year would have required another congressional act to address the problem of reduced Medicare physician payments in 2015; however, a nine-month patch would have preserved the perceived advantage of having several SGR repeal and replace bills that have already been passed by the Senate and House during the 113th Congress (see above). With a full-year override that puts the expiration of the override at the end of March 2015 (if no additional SGR-related legislation is passed during the remainder of 2014), new bills will need to be reintroduced and passed in the 114th Congress. Although nothing precludes Congress from passing an SGR repeal and replace bill during the time remaining in the 113th Congress, the pressure is reduced with the PAMA having moved the date of expiration of the current override until the end of March 2015.

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[69] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=2&vote=00093

[70] http://www.lis.gov/cgi-lis/query/R?r113:FLD001:H52701,H52711

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